

(A)

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF
ILLINOIS

EASTERN DIVISION

JAN 30 2008
FILED

JAN 30 2008 *aw*

LOUIS C. SHEPTIN

MICHAEL W. DOBBINS
CLERK, U.S. DISTRICT COURT

v
P. HARVEY, CLINICAL
DIRECTOR

08-CV-116

SICK CALL AFFIDAVIT

"THE MEANING OF SICK CALL"

1) YOU FILL OUT GREEN FORM

ATTACHED: (SEE ATTACHED)

2) ABOUT 9:00AM TO 10:00AM NURSE

WACKER, MONDAY - FRIDAY COMES

TO EACH UNIT "YELLS:

"SICK CALL"

COLLECTS THE GREEN SLIPS

AND LEAVES.

AND THAT Your Honor is

"SICK CALL"

NO ONE IS EXAMINED AT THIS TIME!
AT MCC Chicago.

I HAVE SENT IN COUNTLESS
SLIPS ONLY TO BE RETURNED

ONE

FROM DENTAL DEPT.

I, LOUIS C. SHEPTIN DEclare
UNDER PENALTY OF PERJURY THE
FOLLOWS IS TRUE & CORRECT. EXECUTED
THIS — DAY OF JANUARY, 2008

CONCURRING
WITNESS

Fred Repp

CONCURRING
WITNESS

James Hogue

CONCURRING
WITNESS

[Signature]

Respectfully,
Signed

[Signature]

LOUIS SHEPTIN

71 W. Webster

MCC-CHICAGO
INMATE SICK CALL SIGN-UP FORM (*Solicitud para Servicios Médicos o Dentales*)

INSTRUCTIONS (Check one) *Instrucciones (Indique uno):* MEDICAL _____ DENTAL _____

1. Name (*Nombre*): _____ Date (*Fecha*): _____
 2. Reg Number (*Número de Registro*): _____ Age (*Edad*): _____
 3. Housing Unit (*Unidad de vivienda*): _____ Work Place (*Lugar de Trabajo*): _____

4. Complaint/Problem: Be very specific (*Queja/Problema - Sea bien específico*) _____

5. How long have you had this problem? (*¿Cuánto tiempo ha tenido este problema?*) _____

6. Are you taking any prescription or over the counter medications at this time? Which ones? (*¿Está tomando medicinas actualmente, con o sin receta? ¿Cuáles?*) _____

7. Are you allergic to any medications? (*¿Es alérgico a algún medicamento?*) _____

8. Are you having any pain? (*¿Está sintiendo dolor?*) _____ If yes, rate the pain from 0-10 _____
 (0= no pain, 10+ worst pain ever)
 (*Si es sí, califíquelo de 0 (no duele) a 10 (el peor dolor que ha sentido)*)

9. Signature (*Firma*) _____

**BRING ALL YOUR PRESCRIBED & COMMISSARY MEDICATIONS TO YOUR APPOINTMENTS
 WITH YOUR PROVIDER.**

**POR FAVOR TRAIGA TODAS LAS MEDICINAS RECETADAS Y DE LA COMISARÍA A SUS
 CITAS CON SU PROVEEDOR DE SERVICIOS DE SALUD.**

TO BE COMPLETED BY MEDICAL PERSONNEL

1. Date triaged: _____ Vital Signs: _____

2. Subjective Information: _____

3. Objective Information: _____

5. Medical Staff Signature and Date: _____

MEDICAL RECORD

RADIOLOGIC CONSULTATION REQUESTS/REPORTS

Attn: Sick Call/Triage

Monday thru Friday, (except Wednesdays, weekends & holidays)

1. Sick call will be conducted by medical staff, Monday thru Friday, (except Wednesdays, weekends & holidays) on your housing unit, starting between the hours of 6:30 am and 7:30 am.

2. To expedite the process please have your sick call form completely filled in **prior** to the sick call times. When sick call is announced on your floor present your completed sick call form to the medical staff member.

ATTACH 2D REPORT WITH TOP AT THIS LINE ▲
ATTACH 1ST REPORT ALONG LEFT MARGIN WITH TOP AT THIS LINE ▲

3. **DO NOT** leave your sick call form on the correctional officer's desk. **YOU** must bring your filled out sick call form to the medical staff member when they announce that sick call/triage is being conducted on your floor.

4. **DO NOT** leave your medication refill request slips on the correctional officer's desk. **YOU** must give your medication refill request slips to the medical staff during sick call/triage to ensure that your medication is refilled. Medication refills will be distributed back to you within three working days. A working day is Monday thru Friday, except holidays. *If you will run out of medication on Friday or the weekend, then be sure to turn in your request slip no later than Tuesday morning sickcall/triage.*

ATTACH REPORTS WITHIN THIS MARGIN